

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

7410 63-029919
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED JUL 25 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4125 St. Louis	
3. NAME OF DECEASED (Type or print) First Middle Last Farmer		4. DATE OF DEATH Month 7 Day 12 Year 63	
5. SEX Fem.	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-12-63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME Leon Farmer		11b. MOTHER'S MAIDEN NAME Betty Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary D. Jett, R.R.L., 2601 N. Whittier		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis Conditions, if any, which gave rise to above cause (e), stating the underlying cause last. DUE TO (b) Prematurity DUE TO (c) 76 2.5		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 7-12-63 to 7-12-63 and last saw her alive on 7-12-63 Death occurred at 2:55 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Signature of physician) Park Whittier 2601 N. Whittier	
22b. DATE 7-31-63		22c. DATE SIGNED 7-15-63	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-31-63	23c. NAME OF CEMETERY OR CREMATOR Anatomical Board	
24. FUNERAL DIRECTOR Address Ozden 4106 Manchester		25. DATE RECD. BY LOCAL REG. JUL 18 1963	
26. REGISTRAR'S SIGNATURE Lead Smith, M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.